Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH DALLAS
3255 WEST PIONEER PARKWAY
ARLINGTON TX 76013

Carrier's Austin Representative Box
Box Number 50

MFDR Date Received
February 24, 2012

Respondent Name
TPCIGA FOR CREDIT GENERAL INDEMNITY CO

MFDR Tracking Number
M4-12-2182-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Since TDI moved to a 143% of DRG for inpatient services on 3/1/08 for hospital claims, or 108% plus the cost of implants x 110% we have reviewed the Medicare allowance and decided the insurance reimbursement does not meet this criteria. Medicare would have allowed this facility $29,794.67 for DRG 467 at 108%. The cost of the implants was $23,573.46 x 110% = $25,930.81. This is a total of $55,725.48. Based on their payment of $45,490.09, a supplemental payment of $10,235.39 is due."

Amount in Dispute: $10,235.39

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary dated March 13, 2012: "We have reviewed the submitted request and determined the charges in dispute warrant additional reimbursement. We show an additional payment in the amount of $2128.21 is due. We were not able to come to the total amount that the requestor is disputing. The requestor has entered the charges into the inpatient pricer with the full billed amount which is applying the outlier to these charges. However, with separate reimbursement for the implants, the total charges do not meet the outlier amount. By excluding the total for the implants the total charges are $63,289.73. The total operating amount is $18,645.88 and the total capital amount is $1,435.13. This is a total of $20,081.01. Therefore, $20,081.01, multiplied by 108% is $21,687.49. We previously reimbursed this amount for all the services excluding the implants. In regards to the implants, only $23,802.60 was originally paid, but $25,930.81 was due. Therefore, the remaining amount due is $2,128.21."

Response Submitted by: Texas Property & Casualty Insurance Guaranty Association, 9120 Burnet Road, Austin TX 78758

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 7, 2011 to July 15, 2011	Inpatient Hospital Surgical Services	$10,235.39	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."
   (3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).
4. 28 Texas Administrative Code §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 143 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated September 13, 2011
   - W1 –WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
   - CHARGE EXCEEDS FEE SCHEDULE ALLOWANCE.
   - REDUCTION IS BASED ON THE INPATIENT FEE SCHEDULE.

   Explanation of benefits dated September 15, 2011
   - W1 –WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
   - CHARGE EXCEEDS FEE SCHEDULE ALLOWANCE.
   - REDUCTION IS BASED ON THE INPATIENT FEE SCHEDULE.

   Explanation of benefits dated October 28, 2011
   - 193 –Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

   Explanation of benefits dated March 12, 2012
   - 193 –Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - W3 –Additional payment made on appeal/reconsideration.

Issues

1. Can the maximum allowable reimbursement (MAR) amount for the disputed services be determined according to 28 Texas Administrative Code §134.404(f)?
2. Did the facility or a surgical implant provider request separate reimbursement for implantables in accordance with 28 Texas Administrative Code §134.404(g)?
3. Is the requestor entitled to reimbursement for the disputed services?

Findings

1. Review of the submitted documentation finds that the maximum allowable reimbursement (MAR) amount for the disputed services can be determined according to 28 Texas Administrative Code §134.404(f).
2. Review of the submitted documentation finds no request for separate reimbursement of implantables in accordance with 28 Texas Administrative Code §134.404(g). Review of the requestor's documentation finds no documentation to sufficiently support that the carrier did receive the billing certification as required for billing separately for implantables. The Division finds that the requestor has not met the requirements of 28 Texas Administrative Code §134.404(g). Consequently, reimbursement will be calculated in accordance with division rule at 28 Texas Administrative Code §134.404(f)(1)(A).
3. Reimbursement for the disputed services is calculated in accordance with 28 Texas Administrative Code §134.404(f)(1)(A) as follows: The Medicare facility-specific reimbursement amount including outlier payment amount for DRG 467 is $27,587.85. This amount multiplied by 143% is $39,450.63. The total maximum allowable reimbursement (MAR) is therefore $39,450.63. The respondent previously paid $45,490.054, therefore an additional amount of $0.00 is recommended for payment.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

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Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 20, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.